Initial Approval: July 9, 2014
Revised Date: October 8, 2014

CRITERIA FOR PRIOR AUTHORIZATION

Enzyme Replacement Therapy

PROVIDER GROUP Pharmacy
Professional

MANUAL GUIDELINES The following drug requires prior authorization:
Eliglustat (Cerdelga®)
Imiglucerase (Cerezyme®)
Taliglucerase Alfa (Elelyso®)
Velaglucerase Alfa (VPRIV®)

CRITERIA FOR ENZYME REPLACEMENT THERAPY Must meet all of the following:

- Patient must have a diagnosis of Type 1 Gaucher disease

LENGTH OF APPROVAL 12 months